



State of California—Health and Human Services Agency
Department of Health Care Services



DAVID MAXWELL-JOLLY

Director

ARNOLD SCHWARZENEGGER

Governor

November 30, 2010
Ms. Margaret Liston, Chief
Financial Management Section

Dear Ms. Liston,

The California Department of Health Care Services (DHCS) is tasked with the development of actuarially sound capitation rate ranges for the County Organized Health Systems (COHS) contracts for the period July 1 2010 through June 30 2011 (FY 10/11). I was the lead Actuary for the FY 10/11 COHS capitation rate process. This letter presents an overview of the analyses and methodology we used in the development of actuarially sound and appropriate managed care rate ranges and payment amounts, and for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS). In my opinion, the capitation rate ranges are developed from an actuarially sound process and should, along with Managed Care Organization (MCO) investment income and any reinsurance or stop-loss cash flows, provide for all reasonable, appropriate and attainable costs. Across all of the COHS plans, the lower bound capitation rate change is 2.5% above current rates. This change reflects the recent revisions in Program Changes assumptions, and the imposition of the MAC pricing adjustments. After adding the QAF (AB1653) payments, IGT payments (San Mateo only), and MRMIB Tax payments, the change in total pmpm payments is 11.0% above current rates. This pmpm payment level applies for the period 07/2010-12/2010. As of 01/2011, the total pmpm payments no longer include the QAF payments. For the period 01/2011-06/2011, the change in total pmpm payments is 3.8% above current rates.

If you have any question on the above, please contact me.

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November 30, 2010

**County Organized Health
System (COHS)
Fiscal Year 2010 – 2011
Rate Range Development and
Certification
State of California**

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Rate methodology

Overview

Capitation rate ranges for DHCS' County Organized Health System (COHS) managed care program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). For rate range development for the COHS Managed Care Organizations (MCOs), we primarily used the COHS plans' reported Rate Development Template (RDT) data for calendar year 2008 (CY2008). We also reviewed CY2008 COHS MCO-reported encounter data, and CY2008 ad hoc claims data reported by the COHS MCOs. The most recently available (at the time the rate ranges were determined) Medi-Cal-specific financial reports submitted to the Department of Managed Health Care (DMHC) were also considered in the rate range development process.

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for the fiscal year 2010/2011 (FY10/11) contract period. Additional adjustments were then applied to the selected base data to incorporate:

- Allocations of capitation payments to categories of service (for Global capitation arrangements, or other capitation arrangements that covered more than one category of service)
- Allocations or re-allocations of health care costs to the standard categories of services
- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Observed changes in the population case-mix and underlying risk of the MCOs from the base data period
- Trend factors to forecast the expenditures and utilization to the contract period
- Administration and Underwriting Profit/Risk/Contingency loading

- Addition of 2.35% premium tax
- Dollar-neutral rate smoothing

A single and consistent process of developing capitation rate ranges was used for the COHS program. Each MCO has the opportunity and responsibility to independently review the rates offered by DHCS, and to determine whether the rates are acceptable based on their individual financial requirements.

The various steps in the rate range development are described in the following paragraphs.

Base data

The information used to form the base data for the COHS rate range development was primarily the 2008 Rate Development Template (RDT) data, submitted by each COHS plan to DHCS. The Base Period that we used for rate development was Calendar Year 2008 (CY 2008) which was the period for which the plans reported their RDT data.

The RDT data was reviewed for consistency and reasonableness within each plan. It was also reviewed for consistency and compatibility with each plan's Medi-Cal specific financial reporting (required by DMHC). We also considered MCO encounter data, and MCO ad hoc claims data. The base data included utilization and unit cost detail by category of aid (COA), by county, and by 12 consolidated provider types or categories of service (COS) including:

- | | | |
|------------------------|--------------------------|------------------|
| ▪ Inpatient Hospital | ▪ Primary Care Physician | ▪ Other Medical |
| ▪ Outpatient Facility | ▪ Specialty Physician | Professional |
| ▪ Emergency Room | ▪ Pharmacy | ▪ Transportation |
| ▪ Long Term Care (LTC) | ▪ Federally Qualified | ▪ All Others |
| ▪ Lab/Radiology | Health Center (FQHC) | |

Utilization and unit cost information from the plan RDT submission was reviewed at the COA and COS detail levels for reasonableness.

In assessing reasonableness of the RDT submission, we examined the RDT data in the following priority order:

- a) The total CY 2008 health care costs reported in the RDT, and implied by the stated pmpm costs for each aid category and the actual CY 2008 enrollment. DHCS actuarial and accounting staff reviewed these amounts for consistency with recent financial reports by the plans (e.g. the filings with the CA Dept of Managed Health Care).
- b) For each aid category, pmpm costs by service category. If pmpm costs by service category appeared unreasonable in the RDT submission, we re-allocated the amounts among the service categories. For the re-allocations, we considered the similar allocations in the FY 09/10 rate development, as

well as our own judgment and experience. The re-allocations did not change the total pmpm amounts within an aid category. Also, the re-allocations were done prior to application of any trend, program changes, or other factors that move the Base Period costs to FY 10/11. That is, we did not attempt to “optimize” the re-allocation to either increase or decrease the plans’ final capitation rates.

We examined the reasonable and appropriate levels of utilization, unit cost, and pmpm amounts that were established in last year’s (FY 09/10) rate development process, for each COS within each COA. In general, the pmpm amounts from the RDT data were compared to the pmpm amounts by COS within each COA. The allocation by COS within each COA was examined, and compared to the FY 09/10 relative costs by COS. When the CY 2008 RDT amounts pmpm were unreasonable by COS, they were re-allocated based on the FY 09/10 base period data; however, the re-allocation did not alter the overall CY 2008 RDT pmpm amounts within a given COS (no net dollar impact).

All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the Program Changes section. The DMHC financial reporting Revenue, Expenses and Net Worth exhibits for each MCO that were available at the time the rate ranges were determined, were reviewed and analyzed by DHCS and Mercer Government Resources Consulting (Mercer).

A requirement of 42 CFR 438.6(c)(4)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, RDT data served as the starting base data for rate setting. Encounters undergo edits within DHCS to ensure quality and the appropriateness of the data for rate-setting purposes. Base period MCO eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services such as abortion. DHCS has relied on data and other information provided by the MCOs in the development of these rate ranges. We have reviewed the data and information utilized for reasonableness, and we believe the data and information to be free of material error and suitable for rate range development purposes for the populations and services covered under the COHS contracts. DHCS or Mercer did not audit the data or information and, if the data or information is materially incomplete or inaccurate, our conclusions may require revision. However, DHCS did perform alternative procedures and analysis that provide a reasonable assurance as to the data’s appropriateness for use in capitation rate development under the State Plan.

Category of Aid (Aid Code) groupings

The base data sets used to develop the COHS FY10/11 capitation rate ranges were divided into cohorts that represent consolidated COA (or Aid Code) groupings which

inherently represent differing levels of risk. These 12 COA cohorts are (alphabetically):

- | | | |
|----------------------|--------------------------|---------------------|
| ▪ Adult | ▪ AIDS/Medi-Cal Only | ▪ Family |
| ▪ Aged/Dual Eligible | ▪ BCCTP | ▪ LTC/Dual Eligible |
| ▪ Aged/Medi-Cal Only | ▪ Disabled/Dual Eligible | ▪ LTC/Medi-Cal Only |
| ▪ AIDS/Dual Eligible | ▪ Disabled/Medi-Cal Only | ▪ OBRA |

The two AIDS categories of aid, as well as OBRA, do not apply in all COHS counties.

Because the COHS program is structured such that only one MCO operates in each county, the distribution of risk between multiple plans is eliminated. Also, coverage is mandatory for virtually all COAs within a COHS county, which also eliminates any selection bias concerns on the part of the participating MCO.

Graduate Medical Education

Regarding Graduate Medical Education (GME) costs and 42 CFR 438.6(c)(5)(v) (along with item AA.3.8 of “Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03”), there are no provisions in the COHS managed care contracts regarding GME. The COHS MCOs do not pay specific rates that contain GME or other GME-related provisions. As COHS data serves as the base data, GME expenses are not part of the COHS capitation rate development process.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the FY10/11 rate range development for the COHS program, DHCS relied on trend recommendations provided by Mercer. Mercer developed trend rates for each provider type or COS, separately by utilization and unit cost components.

Trend information and data were gathered from multiple sources including the MCO encounter data, the MCO requested ad hoc data, MCO financial statements, Medi-Cal fee-for-service experience, historical California Medical Assistance Commission (CMAC) adjustments, Consumer Price Index (CPI) and multiple industry reports. Mercer also relied on professional judgment based upon extensive experience in working with the majority of the largest Medicaid programs in the country. Base data used was trended forward 30 months to the mid-point of the rating period.

Annual mid-point claim cost trends, across all MCOs, all COAs and all 12 COS, average about ½ percent for utilization and 2 percent for unit cost or about 3 percent per member per month (PMPM). The weighted COS PMPM trends vary from a high of about 5¼ percent for Hospital Outpatient and Emergency Room (in some COAs) to a low of about ½ percent for “Other Medical Professional Services”. Note that trends for the LTC provider type are 0.0 percent for both utilization and unit cost. Due to the high level of legislatively-mandated changes surrounding LTC, Mercer has handled LTC trends through the Program Changes portion of the methodology. Given the recent financial information available at the time the rate ranges were developed, the range for the claim cost trend component is +/- ¼ percent per year for each of the utilization and unit cost components, or roughly +/- ½ percent PMPM per year. Over the 2.5 years from CY08 to FY10/11, this contributes almost +/- 1.25 percent to the upper and lower bounds.

Program changes/other adjustments

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. As part of the FY10/11 rate range development for the COHS program, DHCS relied on Program Changes recommendations provided by Mercer. Mercer based their recommendations on information provided by DHCS staff. Following are the program changes (with effective dates) that were viewed to have a material impact on capitation rates, and which were reviewed, analyzed and evaluated by Mercer with the assistance of DHCS’ Managed Care Division and Fiscal Forecasting and Data Management Branch staff:

- LTC rate adjustments – multiple dates
- Hospice rate increases – multiple dates
- Mirena IUC – July 2008
- Provider payment reduction – July 2008 (reflects all refinements [i.e., injunctions] through March of 2010)
- Post-stabilization services reduction – October 2008
- Discontinuation of adult optional benefits – July 2009
- H1N1 Vaccine – October 2009
- Reinstatement of optometry services – July 2010

Any program changes with an effective date prior to January 1, 2009, were treated as retrospective changes.

Efficiency adjustment – Maximum Allowable Cost (MAC)

For the FY10/11 rating period, DHCS is introducing an adjustment to the capitation rates that analyzes the effectiveness of each plan’s pharmacy cost management through a Maximum Allowable Cost (MAC) avoidable cost analysis. Mercer provided these adjustments to DHCS. To identify potentially avoidable costs due to reimbursement inefficiencies, Mercer utilized each plan’s CY2008 pharmacy data

and reviewed the reimbursement contracting for generic products. Each pharmacy claim was compared against a benchmark Medicaid MAC list for the same timeframe to create a cost savings amount for each claim. To calculate the cost savings amount, a derived paid amount which utilized the unit price from the benchmark MAC list was calculated for each claim and subtracted from the actual paid amount on each claim. The total cost savings for each claim was then combined and aggregated for each MCO to calculate the total cost savings for each MCO. In instances where the actual paid amount was less than the derived paid amount (negative cost savings), the negative amount was counted against the savings amount.

In total, across COHS plans, the capitation rates were reduced by an amount of \$2.03 pmpm (-0.7%) as a result of this adjustment.

Administration and Underwriting Profit/Risk/Contingency loading

DHCS requested FY 10/11 that Mercer recommend amounts for administration and profit/risk/contingency loading.

The administration loading for each of the MCOs was developed separately. The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). These percentages were developed from a review of the MCOs' historical reported administrative expenses. Mercer utilized its experience and professional judgment in determining the recommended percentages to be reasonable. DHCS reviewed the Mercer recommended amounts, and determined that a Lower Bound administration allowance of 4% for CalOptima, and 5% for each of the other COHS organizations, is reasonable and consistent with the Mercer recommended amounts. The range for the Administration component is +/- 0.25 percent upper/lower bound from the mid-point value.

The Underwriting Profit/Risk/Contingency load is 3.0 percent at the mid-point, 2.0 percent at the lower bound and 4.0 percent at the upper bound. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions. Mercer has concluded that the assumptions surrounding the Underwriting Profit/Risk/Contingency load, as well as income an MCO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical health plan.

Premium Tax

The COHS plans must pay a "premium tax" of 2.35% of total capitation payments (including the premium tax). So, all capitation payment pmpm amounts must include an additional amount for the premium tax. This applies to the rate ranges, as well as any additional amounts for QAF and IGT.

Rate smoothing

The COHS program is large, covering several hundred thousand lives. In aggregate, each MCO has a fully credible population base for rate-setting purposes. However, there are a number of COAs within each county for which there is concern over specific COA credibility.

After the initial calculation of projected FY10/11 rates, other smoothing took place as follows. First, the initial rate calculations for Dual and Medi-Cal Only (MCO) were compared to the FY10/11 Dual/MCO rates for the Aged, Disabled, and Long Term Care (LTC) COA. The FY10/11 Dual/MCO rate relationship within each of these COA (Aged, Disabled, LTC) was re-allocated to preserve the Dual/MCO relationship from FY 09/10. This method indirectly causes the FY10/11 rates to reflect the smoothing techniques that were employed in the FY 09/10 and FY 08/09 rates. The Dual/MCO smoothing was calculated in a revenue-neutral manner to each Plan (no expected revenue dollars were gained or lost in this process).

Second, the BCCTP and OBRA (where available) rates were re-allocated with the Adult/Family rate, to preserve the relative relationship of the FY 09/10 rates. Again, this rate smoothing was calculated in a revenue-neutral manner.

Rate ranges

DHCS calculated rate ranges, which were developed using an actuarially sound process. The COA-specific rate ranges were developed using a combination of a modeling process which varied the medical expense (i.e., risk) trend, the administration loading percentage, and the Underwriting/Profit/Risk/Contingency loading percentage to arrive at both an upper and lower bound capitation rate. The final contracted rates agreed to between DHCS and each MCO fall within the rate ranges.

Additional Payments for AB1653 (QAF)

Also, effective for the first six months (July 2010 through December 2010) of the FY 10/11 contract period, a legislated policy change, Assembly Bill 1653 (AB 1653), is incorporated into the actuarially sound capitation payment amounts. This policy change increases the Medi-Cal fee-for-service (FFS) inpatient payment levels in total approximately 40% and the Medi-Cal FFS outpatient hospital and emergency room payment levels in total approximately 92%. The associated managed care service category increases, being implemented at approximately 60% of the FFS increase levels, are applied to the managed care inpatient, outpatient hospital and emergency room unit costs. The specific program change for inpatient unit costs is 20.2% and the program change for outpatient hospital and emergency room unit costs is 51.0%.

Since AB 1653 is only effective for the first six months of FY 10/11, the rate increases caused by this policy change are only applied to the rates for the first six months of FY 10/11. This creates two sets of rates that will be paid in FY 10/11: the set of rates used for the first six months and the set of rates used for the final six months of the contract period (which is FY 10/11). The difference is that the rates used for the first six months have additional increases to account for the AB 1653 policy change. Because of the size of these increases to the hospital unit costs within the capitation rates, the administrative costs and underwriting profit/risk/contingency PMPM amounts were maintained at the levels established prior to applying the AB 1653 program change. However, since the increased payments will be subject to the 2.35% California premium tax, the increases caused by the AB1653 adjustments were increased by 2.35% (i.e. divided by 0.9735).

The payment amounts pertaining to AB1653 are sometimes called "Quality Assurance Fee" or QAF amounts.

Additional Payments for Intergovernmental Tax (IGT)

The FY 10/11 capitation rates for San Mateo county have an additional pmpm payment amount for IGT. The pmpm amounts were developed so that the annual payments to Health Plan of San Mateo will increase by \$28,673,835. This amount is \$28 million, increased by 2.35% for the California Premium Tax.

Additional Payments for MRMIB Premium Tax

For some counties, a small additional amount was added to the Adult/Family capitation payments. Through an agreement between DHCS and MRMIB, DHCS pays COHS plans the expected amount of MRMIB premium tax to be assessed in FY 10/11.

Rate range certification

In preparing the rate ranges described, I have used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by our staff at DHCS and by the COHS plans. DHCS staff has reviewed the data and information for internal consistency and reasonableness, but we did not audit it. I relied on Mercer for the reasonableness, appropriateness, and amounts of the MAC pricing adjustments and the QAF payments. In my opinion the data used for the rate development process is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report and associated exhibits may need to be revised accordingly.

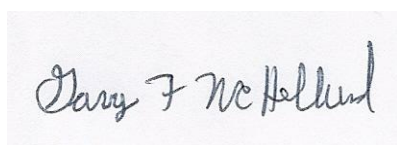
I certify that the COHS FY10/11 rate ranges were developed in accordance with generally accepted actuarial practices and principles. I am an actuary meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract.

Rate ranges are actuarial projections of future contingent events. Actual results will differ from these projections. DHCS has developed these rate ranges and payment amounts to demonstrate compliance with the CMS requirements under 42 CFR § 438.6(c) and in accordance with applicable law and regulations. MCOs are advised that the use of these rate ranges, or the resulting final rates within these ranges, may not be appropriate for their particular circumstance and DHCS disclaims any responsibility for the use of these rate ranges or rates by the MCOs for any purpose. DHCS recommends that any MCO considering contracting with DHCS should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rate ranges and resulting rates before deciding whether to contract with DHCS. Use of these rate ranges and resulting rates for any purpose beyond that stated may not be appropriate. I also certify that the additional payment amounts, for QAF, IGT, and MRMIB Tax, were appropriately added to the COHS FY 10/11 capitation payment rates.

MCOs are advised that the use of these rate ranges may not be appropriate for their

particular circumstance and DHCS disclaims any responsibility for the use of these rate ranges by MCOs for any purpose. We recommend that any MCO considering contracting with DHCS should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rate ranges before deciding whether to contract with DHCS.

This certification letter assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules and actuarial rating techniques. It is intended for DHCS and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

A handwritten signature in cursive script that reads "Gary F McHolland". The signature is written in dark ink on a light-colored, slightly textured background.

Gary F. McHolland, A.S.A., M.A.A.A.